PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D38

PROVIDER -
Select Specialty Hospital - Houston Heights
Houston, TX

Provider No.: 45-2049

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING
August 20, 2004

Cost Reporting Period Ended -
August 31, 1999

CASE NO.: 02-2031

INDEX

ISSUE:

Whether the Intermediary erred in denying the Provider a continuous improvement bonus ("CIB") for fiscal year ending August 31, 1999.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board or PRRB) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under Medicare Part A, participating institutions are reimbursed either based on their actual costs of providing services or pursuant to a formula that is based on a preset payment per discharge for various types of diagnoses under a prospective payment system (PPS). Long-term acute care hospitals (LTACs) are among the group of participating institutions that were excluded from hospital inpatient PPS when it was implemented in 1984. See 42 U.S.C. §1395ww(d); 42 C.F.R. §412.23(e).

Although not subject to payment limitations under PPS, LTACs during the period in question were subject to other payment limitations and incentives, including the continuous improvement bonus (CIB). Congress established the CIB with the goal of rewarding providers that kept cost per discharges under certain limits by providing for a bonus or incentive payment. Congress provided that such a bonus could be paid to an "eligible hospital" defined as one that has, among other things, received payment as a PPS-exempt hospital for "at least 3 full cost reporting periods before the cost reporting period" for which the hospital seeks a bonus. (emphasis added.) 42 U.S.C. §1395 ww(b)(2)(B)(i). Accordingly, DHHS promulgated regulations that limited eligibility for

CIB payments to hospitals that were paid as a PPS- exempt hospital "for at least three full cost reporting periods prior to the applicable period…." (emphasis added.) 42 C.F.R. §413.40(d)(5).

Background of the Dispute

The following timeline outlines the relevant time periods in this case:

9/1/94 - Provider opens.

3/1/95 - Provider receives Medicare certification

3/1/95 to 2/29/96 -12 month cost reporting period

3/1/96 to 2/28/97 - 12 month cost reporting period

3/1/97 to 8/31/97 - 6 month cost reporting period (as a result of a change in fiscal year end (FYE))

9/1/97 to 7/31/98 -11 month cost reporting period (as a result of a change in ownership)

8/1/98 to 8/31/99 - 13 month cost reporting period

Data contained on lines 58.01 – the expected cost line and 58.02 – the trended cost line of Worksheet D-1, Part II of CMS form 2552-96 are used to compute the CIB. Unless data is input on both lines, no CIB computation is triggered. For FYE 8/31/99, the Provider filed its cost report without populating the either line 58.01 or line 58.02, both of which are necessary to calculate the CIB. The Intermediary adjusted the expected cost line, but it did not complete the trended cost line. Since neither the Provider nor the Intermediary completed all of the lines necessary to make the calculation, the Provider did not receive a CIB. The NPR was issued on February 28, 2002 and, the Provider filed a timely appeal objecting to the Intermediary's failure to populate the trended cost line so that the CIB calculation could be completed.

The Provider was represented by Laura J. Oberbroeckling, Esq. of Reed Smith L.L.P. The Intermediary, Mutual of Omaha, was represented by Richard Lee, Appeals Consultant.

JURISDICTIONAL CHALLENGE

The Intermediary contends that the Board lacks jurisdiction over this case. The Intermediary explains that as the Provider failed to claim a CIB on its cost report and neglected to exhaust its administrative remedies, the issue is not covered by the cost report in accordance with 42 U.S.C. §1395oo(d). Furthermore, since no legal authority precluded the Provider from claiming a CIB, nor did the Provider claim the CIB as a

protested item, the CIB was not a self-disallowed cost to which the decision Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399 (1988) applies. The Intermediary also contends that implicit throughout 42 C.F.R. §§405.1801 and 405.1803 is the rule that an identifiable adverse finding is necessary to request a Board hearing. The Intermediary noted that the Provider's reimbursement manager testified that he had the data to determine if the Provider qualified for the CIB and he wished that he had claimed it.

The Provider responds that Board jurisdiction exists because the Provider appealed the Intermediary's decision not to populate the trended cost line (line 58.02) of the cost report while adjusting the expected cost line (line 58.01). The Provider explains that the Intermediary's completion of the expected cost line gives rise to the appeal of the CIB. Referencing Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399, 404 (1988) and Maine General Medical Center v Shalala, 205 F.3d 493 (1st Cir. 2000), the Provider contends that, even if the Intermediary had not adjusted the expected cost line, the Provider would have the right to appeal the Intermediary's decision not to grant the hospital a CIB. The Provider also states that no statute or regulation requires that the Intermediary make an identifiable adverse decision for the Board to have jurisdiction.

The Board majority finds that it has jurisdiction over this case as the Intermediary made an adjustment to the expected cost line (line 58.01).

PROVIDER'S CONTENTIONS

The Provider contends that it is eligible for a CIB as it operated as a LTAC for at least three full cost reporting periods, totaling 41 months, before the subject period, and its operating costs per discharge were below the statutory targets. The Provider claims that the requisite third full cost reporting period could be created by combining the FYEs 8/31/97 (6 months) and 7/31/98 (11 months) cost reporting periods. This solution, which encompasses four cost reporting periods over a 41-month span, addresses the Intermediary's concern of using a time span less than 36 months. Additionally, combining FYEs 8/31/97 and 7/31/98 would not result in skewed statistics (due to increased year-end holiday discharges) as these cost years both end in the summer. The Provider asserts that the Intermediary's application of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) ceiling implies that the cost of operations for cost reporting periods less than12 months long may be used to calculate the CIB.

Also, in response to the Board's hearing request, the Provider filed a Supplemental Submission which indicated that the Provider would be eligible for a CIB if the 11-month cost reporting period from 9/1/97 though 7/31/98 were extended to 12 months by adding either August 1997 or August 1998.[1] The Provider also notes that there are situations in

[1] See Supplemental Submission, "Question 2". The Board notes that the Provider's Question 2 states: "Would Houston Heights have been eligible for a CIB if the eleven-month period from September 30, 1997 through July 31, 1998 were extended by one month by either (1) adding August 1997 or (2) adding August 1998?" (emphasis added.) The Provider's statement that the period began on September 30, (rather than

which cost reports may lawfully cover periods other than 12 months. Likewise, the Provider argues that the Intermediary incorrectly interprets a "full cost report" as being 12 months long.[2]

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the third "full" cost reporting period is the FYE 8/31/99, and the Provider, accordingly, would not qualify for a CIB. The Intermediary explains that as 42 C.F.R. §413.40(b)(1) describes short reporting periods as "fewer than 12 months," a full cost report would contain 12 months or more. Also, short periods may not be representative of operating costs. The Provider should not be allowed to use a 17-month cost reporting period, as no 17-month cost report was filed. The Intermediary contends that there are other regulations and a manual provision (not explicitly addressing the CIB) which indicate that a full cost reporting period is at least 12 months long.[3] Also, hypothetically, if short periods were considered to qualify for a CIB, the statistics could be skewed due to increased discharges which often occur in December.

September 1, 1997) is a harmless misstatement since the Provider's answer recognized the correct cost reporting period.

[2] See Provider Supplemental Position Paper at n.1. The Provider argues that the Intermediary's attempts to bolster its interpretation of "full" by referring to other regulations are flawed. The Provider states that:

> "all but one of the regulations cited by the Intermediary modify 'full' cost report with the phrase '12-month.' This suggests that 'full' does not necessarily mean 12 months in length, as the Intermediary maintains, as the description of a cost reporting period as both 'full' and '12-month' would be redundant and unnecessary. Presumably, the Secretary purposely chose to modify 'full cost reporting period' with '12-month,' as an agency is presumed to act intentionally and purposely when it includes language in one section but omits it in another" (citations omitted.)

[3] The Intermediary cites 42 C.F.R. §413.30(a) and 413.30(b)(3) and (4), alleging that the terms "full 12-month cost reporting period" and "first full cost reporting period" are used interchangeably. Likewise, 42 C.F.R. §412.23(b)(2) and (8), respectively, use the phrases: "first 12-month cost reporting period" and "first full 12-month cost reporting period. " The Intermediary also cites P.R.M. §3003.6C, which includes an example that states: "At the end of its first full cost reporting period, January 1, through December 31, 1993. . . ."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence presented and the parties' contentions, finds that the methodology within the Provider's Supplemental Submission, in which data from FYEs 2/28/96, 2/28/97 and the period between August 1, 1997 though July 31, 1998 is utilized, is acceptable.

The Board finds that no controlling authority definitively states whether a cost reporting period other than 12 months is a "full" cost reporting period. Likewise, the parties' opposing statutory and regulatory construction analyses were both well reasoned yet inconclusive.[4]

The Board concludes that Congress' purpose is clear: it intended that providers who kept costs below certain limits for at least 36 months could qualify for a CIB. Additionally, there is no evidence that Congress intended that providers whose performance had improved over a 36-month period should be disqualified for a CIB simply because some of its cost reporting periods were not 12 months long, particularly given the fact that providers may lawfully use reporting periods other than 12 months in certain circumstances. Accordingly, the Board finds that the methodology using data from FYEs 2/28/96, 2/28/97, and the period between August 1, 1997 through July 31, 1998 is acceptable for the calculation of Provider's CIB eligibility.

DECISION AND ORDER:

The Board finds that the Intermediary should make an adjustment in accordance with the methodology outlined in the Provider's Supplemental Submission in which the Provider uses data from the cost reporting periods ending 2/28/96, 2/28/97, and the period between August 1, 1997 through July 31, 1998 to determine whether the Provider is eligible for a CIB.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A. (Dissenting as to Jurisdiction)
Anjali Mulchandani-West

FOR THE BOARD:

DATE: May 10, 2005

Suzanne Cochran
Chairperson

[4] 42 C.F.R. §413.24(f); P.R.M. II §102.

Dissenting Opinion of Elaine Crews Powell, C.P.A.

I respectfully disagree with the majority's opinion accepting jurisdiction over this case. My colleagues believe that because the Intermediary made an adjustment to the expected cost on line 58, the Board has jurisdiction over the Provider's appeal involving the trended cost line and the Continuous Improvement Bonus (CIB). I dissent.
42 U.S.C. §1395oo(a) dictates that to obtain Board jurisdiction, a provider must be "dissatisfied" with a "final determination" of the Intermediary. Thus, it follows that a provider must claim reimbursement for items and services on its cost report in order for the Intermediary to make a "final determination" regarding such items and services. Likewise, a provider can not be "dissatisfied" under 42 U.S.C. §1395oo(a) if no final determination was made by the Intermediary.

The Supreme Court in Bethesda Hospital Ass'n provided an exception to the requirement that a provider must claim the costs on its cost report in order to obtain Board jurisdiction. In Bethesda, the petitioners did not claim reimbursement for the costs that they eventually appealed because the Intermediary was precluded by the Secretary' s regulations from reimbursing the petitioners for the costs. Since it was futile for the petitioners to claim the costs, the petitioners filed cost reports that fully complied with the regulations. The Court concluded that the petitioners in Bethesda "stand on different ground" than providers "who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules." Regarding the latter described providers, the Court stated "such defaults might well establish that a provider was satisfied with amounts requested in its cost report and awarded by the fiscal intermediary."

The present case does not involve the exception situation described in Bethesda, as the Provider was not challenging the validity of a statute, regulation, or manual provision in which it would clearly be futile to claim reimbursement. In this case, the Provider's witness testified that he was not prohibited from making a claim for the CIB.[5] The fact that the Intermediary made an adjustment to the expected cost line in the CIB calculation does not give rise to jurisdiction. Therefore, the Provider fails to meet the dissatisfaction requirement of 42 U.S.C. §1395oo(a).

Regarding the merits of this case, I am in full agreement with my colleagues.

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Elaine Crews Powell, C.P.A.

[5] Tr. 34-35, 47-48.